FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039545

Facility Name: Greenwood Manor West

Address: 608 West Pearl (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-4312 **Fax #** (618) 498-9575

IDPA ID Number: 371324091001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Barbara Molloy **Telephone Number:** (618) 498-4312

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Barbara Molloy
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Dennis E. Ulrich, Certified Public Accountant
(Firm Name & Address) Scheffel & Company, P.C.
143 North Kansas Street, Edwardsville, IL 62025
(Telephone) (618) 656-1206 Fax # (618) 656-3536

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	48	TOTALS	48	17,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,228	3,890		14,118	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,228	3,890		14,118	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.58%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/05/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/05/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	64,799	10,268	5,539	80,606		80,606		80,606			1
2	Food Purchase		66,102		66,102		66,102		66,102			2
3	Housekeeping	34,489	4,825		39,314		39,314		39,314			3
4	Laundry	38,900	11,435		50,335		50,335		50,335			4
5	Heat and Other Utilities			42,963	42,963		42,963		42,963			5
6	Maintenance			10,997	10,997		10,997		10,997			6
7	Other (specify):*											7
8	**TOTAL General Services**	138,188	92,630	59,499	290,317		290,317		290,317			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	441,828	37,378	46,179	525,385		525,385		525,385			10
10a	Therapy	646		1,860	2,506		2,506		2,506			10a
11	Activities	19,182	3,703	4,768	27,653		27,653		27,653			11
12	Social Services	16,470			16,470		16,470		16,470			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	478,126	41,081	55,307	574,514		574,514		574,514			16
	C. General Administration											
17	Administrative	27,868		1,190	29,058		29,058	(1,190)	27,868			17
18	Directors Fees											18
19	Professional Services			35,961	35,961		35,961		35,961			19
20	Dues, Fees, Subscriptions & Promotions			7,168	7,168		7,168	(5,091)	2,077			20
21	Clerical & General Office Expenses	16,629	13,476	22,947	53,052		53,052	(279)	52,773			21
22	Employee Benefits & Payroll Taxes			114,036	114,036		114,036		114,036			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,210	2,210		2,210		2,210			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			29,684	29,684		29,684		29,684			26
27	Other (specify):*											27
28	**TOTAL General Administration**	44,497	13,476	213,196	271,169		271,169	(6,560)	264,609			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	660,811	147,187	328,002	1,136,000		1,136,000	(6,560)	1,129,440			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenwood Manor West #0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,648	27,648		27,648	4,637	32,285			30
31	Amortization of Pre-Op. & Org.			467	467		467		467			31
32	Interest			3,565	3,565		3,565	12,212	15,777			32
33	Real Estate Taxes							5,525	5,525			33
34	Rent-Facility & Grounds			21,600	21,600		21,600	(21,600)				34
35	Rent-Equipment & Vehicles			1,661	1,661		1,661		1,661			35
36	Other (specify):*											36
37	**TOTAL Ownership**			54,941	54,941		54,941	774	55,715			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,780	28,780		28,780		28,780			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			28,780	28,780		28,780		28,780			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	660,811	147,187	411,723	1,219,721		1,219,721	(5,786)	1,213,935			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	147	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,190)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(325)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,836)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,459)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	673		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 673		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,786)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Greenwood Manor West

ID# 0039545

Report Period Beginning: 1/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Manor West # 0039545 **Report Period Beginning:** 1/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,190)	0	0	0	0	0	0	0	0	0	0	(1,190)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,091)	0	0	0	0	0	0	0	0	0	0	(5,091)	20
21	Clerical & General Office Expenses	(325)	46	0	0	0	0	0	0	0	0	0	(279)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,606)	46	0	0	0	0	0	0	0	0	0	(6,560)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,606)	46	0	0	0	0	0	0	0	0	0	(6,560)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Manor West # 0039545 **Report Period Beginning:** 1/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	147	4,490	0	0	0	0	0	0	0	0	0	4,637	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	12,212	0	0	0	0	0	0	0	0	0	12,212	32
33	Real Estate Taxes	0	5,525	0	0	0	0	0	0	0	0	0	5,525	33
34	Rent-Facility & Grounds	0	(21,600)	0	0	0	0	0	0	0	0	0	(21,600)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	147	627	0	0	0	0	0	0	0	0	0	774	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,459)	673	0	0	0	0	0	0	0	0	0	(5,786)	45

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lawrence B. Plummer	100.0	Greenwood Manor, Inc.	Jerseyville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Lawrence Plummer	100.00%	$ 4,490	$ 4,490	1
2	V	32	Interest		Lawrence Plummer	100.00%	12,212	12,212	2
3	V	33	Real Estate Taxes		Lawrence Plummer	100.00%	5,525	5,525	3
4	V	34	Rent	21,600	Lawrence Plummer	100.00%		(21,600)	4
5	V	21	Clerical		Lawrence Plummer	100.00%	46	46	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 21,600			$ 22,273	$ * 673	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Barbara Molloy	Administrator	Administrator	0.00	17,871	40	100.00	Wages	$ 27,868	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,868		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank Consolidation/			Share of Operating LOC Interest				Allocated from Greenwwod			3,565	6
7	Greenwood											7
8												8
9	TOTAL Facility Related						$	$			$ 3,565	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 3,565	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	5,525	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,525	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	5,525	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	4,575	8
	1999	4,654	9
	2000	4,543	10
	2001	4,543	11
	2002	4,974	12

Line 2 is 2002 taxes paid in 2003.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Manor West COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039545

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (618) 498-4312 FAX #: (618) 498-9575

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-562-001-00	Hill's Addition Lot 2, 3, 5	$ 5,023.44	$ 5,023.44
2.	04-562-002-00	Hill's Addition Lot 1, 2, 5, 6	$ 502.02	$ 502.02
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,525.46	$ 5,525.46

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,668 B. General Construction Type: Exterior BLOCK Frame WOOD Number of Stories ONE

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 11,957
2. Number of Years Over Which it is Being Amortized: 5-15 YEARS
3. Current Period Amortization: 467
4. Dates Incurred: 4/94 Legal, 10/94 Noncompete Agreement, Goodwill, Patient list

Nature of Costs: Legal - $4,957, Noncompete Agreement - $5,000, Goodwill & Patient list - $2,000
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	To accommodate Bldg.			$	1
2	and parking	28,741	1994	25,000	2
3	TOTALS	28,741		$ 25,000	3

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1994		$ 175,130	$ 4,491	40	$ 4,491	$	$ 40,877	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling			1994	80,562	2,066	30	2,685	619	25,608	9
10	Call Lite System			1994	13,123		15	875	875	8,238	10
11	Door Control System			1994	3,858		20	193	193	1,784	11
12	Blinds, Rods, Drapes, & Curtains			1994	14,238		12	1,186	1,186	10,489	12
13	Cabinets			1994	3,702		20	185	185	1,682	13
14	Monitor, Cameras, & Closed Circuit TV			1994	5,619		20	281	281	2,646	14
15	Flooring			1994	1,946		8			1,946	15
16	Air Conditioners			1994	2,341		8			2,341	16
17	Over-the-bed Light Fixtures			1994	4,510		8			4,510	17
18	Carpet			1994	38,729		5			38,729	18
19	HVAC System			1994	29,750	763	20	1,488	725	14,255	19
20	Fire Alarm System			1994	989		20	49	49	466	20
21	Handicap Water Cooler			1994	995		10	100	100	904	21
22	Shampoo Bowl			1994	233		10	23	23	212	22
23	Water Heater			1994	5,149		15	343	343	3,118	23
24	Remodeling			1995	436	11	30	15	4	131	24
25	Remodeling			1995	160	4	30	5	1	48	25
26	Door Control Keypad			1995	273		20	14	14	123	26
27	Remodeling			1995	625	16	30	21	5	186	27
28	Remodeling			1995	478	12	30	16	4	139	28
29	Tile Floor			1995	266		8	8	8	266	29
30	Light Fixtures			1995	198		8	6	6	198	30
31	Laundry Room Remodeling			1995	12,793	328	30	426	98	3,731	31
32	Heating Duct Work			1996	8,250	212	20	413	201	2,991	32
33	Landscaping			1997	3,535	555	20	177	(378)	1,178	33
34	Remodeling- Fire Walls, etc.			2000	7,810	195	40	195		635	34
35	Rewiring			2000	6,169	154	40	154		527	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ceiling Fans	7/19/2001	$ 1,062	$ 186	15	$ 106	$ (80)	$ 257	37
38	Boiler in Mechanical Rooms	1/27/2001	4,200	359	20	210	(149)	613	38
39	Painting	4/3/2001	2,128	182	5	426	244	1,170	39
40	Asphalt Driveway, Sides & Back	9/17/2001	5,242	448	8	655	207	1,474	40
41	2 Fire-Rated Doors - Dietary	11/13/2001	1,053	184	20	53	(131)	114	41
42	Roof	6/20/2003	24,009	12,605	40	300	(12,305)	300	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 459,561	$ 22,771		$ 15,099	$ (7,672)	$ 171,886	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 172,023	$ 7,204	$ 16,820	$ 9,616		$ 123,915	71
72	Current Year Purchases	3,784	2,163	366	(1,797)	10	366	72
73	Fully Depreciated Assets	6,959					6,959	73
74								74
75	TOTALS	$ 182,766	$ 9,367	$ 17,186	$ 7,819		$ 131,240	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 667,327	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,138	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,285	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 147	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 303,126	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,661 Description: $599 Dishwasher, $976 Postage Meters, $86 Pagers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,721	$ 3,721	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	230,837	230,837	3
4	Supply Inventory (priced at COST)	3,000	3,000	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,901	11,901	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		35,206	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 249,459	$ 284,665	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	7,242	7,242	11
12	Long-Term Investments			12
13	Land		25,000	13
14	Buildings, at Historical Cost		175,130	14
15	Leasehold Improvements, at Historical Cost	309,431	309,431	15
16	Equipment, at Historical Cost	182,765	182,765	16
17	Accumulated Depreciation (book methods)	(315,638)	(356,988)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,957	11,957	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,934)	(9,934)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	3,225	3,225	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 189,048	$ 347,828	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 438,507	$ 632,493	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,710	$ 152,710	26
27	Officer's Accounts Payable	773,902	773,902	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,777	26,777	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,461	1,461	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATES	463,670	474,214	36
37	PROVIDER TAX - PAYABLE	2,500	2,500	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,421,020	$ 1,431,564	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,421,020	$ 1,431,564	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (982,513)	$ (799,071)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 438,507	$ 632,493	48

***(See instructions.)**

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (827,393)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (827,393)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(155,120)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (155,120)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (982,513)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,064,601	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,064,601	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,064,601	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	290,317	31
32	Health Care	574,514	32
33	General Administration	271,169	33
	B. Capital Expense		
34	Ownership	54,941	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	28,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,219,721	40
41	**Income before Income Taxes (line 30 minus line 40)****	(155,120)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (155,120)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No, cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	1,995	$ 35,818	$ 17.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,165	1,162	17,854	15.36	3
4	Licensed Practical Nurses	11,287	11,863	151,254	12.75	4
5	Nurse Aides & Orderlies	23,570	24,467	219,226	8.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	47	47	646	13.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,074	2,192	19,182	8.75	9
10	Activity Assistants					10
11	Social Service Workers	1,800	1,920	16,470	8.58	11
12	Dietician					12
13	Food Service Supervisor	1,792	1,966	16,769	8.53	13
14	Head Cook	4,091	4,229	30,406	7.19	14
15	Cook Helpers/Assistants	2,554	2,554	17,624	6.90	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,999	4,155	34,489	8.30	18
19	Laundry	5,349	5,463	38,900	7.12	19
20	Administrator	1,960	2,080	27,868	13.40	20
21	Assistant Administrator					21
22	Other Administrative	575	546	3,641	6.67	22
23	Office Manager					23
24	Clerical	1,360	1,290	12,988	10.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	2,531	2,525	17,676	7.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	66,154	68,454	$ 660,811 *	$ 9.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	135	$ 5,539	1-3	35
36	Medical Director		2,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	1,040	10-3	39
40	Physical Therapy Consultant	19	1,065	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	795	10a-3	43
44	Activity Consultant	78	4,768	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Care Plan Consultant	98	3,408	10-3	47
48	OSHA Consultant		691	10-3	48
49	TOTAL (lines 35 - 48)	335	$ 19,806		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	708	$ 27,883	10-3	50
51	Licensed Practical Nurses	430	13,157	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,138	$ 41,040		53

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Molloy	Administrator	0	$ 27,868
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,868

B. Administrative - Other

Description	Amount
Sales Tax	$ 1,190
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,190
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Automated Data Processing	Payroll	$ 4,728
Scheffel & Company, P.C.	Accounting	28,605
McMahon, Berger	Legal	303
Stratton, Giganti, Stone	Legal	1,725
Ross Breitweiser	Computers	600
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,165
Unemployment Compensation Insurance	11,964
FICA Taxes	50,434
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	473
TOTAL (agree to Schedule V, line 22, col.8)	$ 114,036

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	460
Health Care Worker Background Check	
(Indicate # of checks performed 54)	584
Dues and Subscriptions	862
Advertising and Promotion	5,108
Taxes & License	154
Less: Public Relations Expense	(2,255)
Non-allowable advertising	( )
Yellow page advertising	(2,836)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,077

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,210
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,210

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Greenwood Manor West **#** 0039545 **Report Period Beginning:** 1/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,562** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **28,780**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **0%**

d. Have vehicle usage logs been maintained? **N/A**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A <$2,500**
Attach invoices and a summary of services for all architect and appraisal fees.